ASAM Levels of care

Brad DeCamp - Executive Director
Crawford-Marion ADAMH Board

Joyce Starr LSW, LICDC, ICADAC –
Chief of Addiction Services –
Ohio Department of Mental Health and Addiction Services
PLAN FOR THE DAY –

What are we going to cover?

- What is the ASAM criteria
- How using the ASAM criteria in assessments can improve treatment
- What are the six Dimensions of the ASAM Criteria
PLAN FOR THE DAY – What are we going to cover?

- Determining Risk Factors
- Values and operational elements of ROSC
- BH redesign and new billing components
- Multidimensional assessment components
Learning objectives:

- Understanding the different assessment dimensions
- Recognize the criteria used to differentiate the levels of care for consumers with substance use disorders
- Understand Continued stay and discharge Criteria
How do we decide what type of treatment or services our client needs?
Do we use different Lenses to determine treatment?

- Was is court ordered?

- This is what level of care our agency has available?

- What is the funding source?
“History” of ASAM Criteria

- American Society of Addiction Medicine was founded in 1950 by a group of physicians interested in addictions treatment to address the lack of: common language, systematic assessment and approach, effective patient centered treatment plans.

- A national guideline for placement, continued stay and discharge of patients was established

- Through the years, input from physicians, counselors, social workers and psychologists transpires
“History” of ASAM Criteria

- Previous versions have been continuously reviewed and critiqued to assist in creating the most useful manual as possible.

- The ASAM Criteria was initially developed in (1991) and was revised in (1996) and again in (2001).

- The current third revision was copyrighted in (2013).
Why is ASAM Criteria used?

- Used as a clinical guide along with your “Clinical Judgement” to improve assessment and outcome driven treatment and recovery services.

- To match patient to appropriate types and levels of services they need for successful and long term recovery.
What is the purpose of ASAM criteria

- To enhance use of multidimensional assessments.
- To develop Patient-centered service plans.
- To assist clinicians in making objective decisions regarding patient placement for levels of care.
What are the advantages of ASAM

- Provides Universal Language to improve communication within and across systems including insurers, payers and manage care companies.
- It is a nationally recognized standard for assessment and placement
- It improves treatment planning and outcomes
- It maximizes resources
- It makes clinician work easier and less stressful
Defining Recovery

**Webster:** The act or process of becoming healthy after an illness or injury; the act or process of recovering.

**SAMHSA:** A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
Guiding Principles of Recovery

- Recovery Emerges from Hope
- Recovery is person driven
- Recovery occurs via many pathways
- Recovery is holistic
- Recovery is supported by peers and allies
- Recovery is culturally-biased and influenced
- Recovery is supported by addressing Trauma
- Recovery involves individual, family, and community strengths and responsibility
- Recovery is based on Respect.

Http://www.samhsa.gov/recovery/
ASAM Guiding Principles

- Multi-Dimensional Assessment
- Variable Length of Service
- Focus on Treatment Outcomes
- Clinically-Driven Care and Outcomes Driven Treatment
- Interdisciplinary, Team Approach to Clinically-Driven Care
- Incorporating ASAM Definition of Addiction
- Broad and Flexible Continuum of Care
- Informed Consent
- No need to “fail out” of Treatment
- Clarifying Role of Physician

ASAM Criteria 3rd Ed, p. 3
Comparison to ROSC
Values/Operational Elements

- Person-centered
- Self-directed
- Strength-based
- Participation of family members, caregivers, significant others, friends, and community
- Individualized, comprehensive services and supports
- Community-based services and supports
- Continuity of services and supports
- Service quality and responsiveness
- Outcomes-driven
  - For the individual
  - For the system
- Adequately and flexibly funded
Key concepts to Remember about Addiction:

- Substance Use Disorders are biopsychosocial – spiritual in nature
- Denial and resistance are major signs and symptoms characteristic of dependency
- Family Disease concept
  - Children, spouses, and significant others may act to maintain and prolong addiction. Need to engage in a personal recovery.
The ♡ of Client-Directed Care

- Builds a therapeutic alliance
- Come to agreement regarding: **Goals-Strategies-Method**
- Client needs to be engaged to produce effective outcomes
Advantages of Client-Directed Care

- Efficient use of limited resources
- Lengths of stay should be determined by client need and progress
- Increase retention rates
- Flexible levels of care (mixture of recovery housing and IOP)
- Client and clinician determine level of treatment – least intensive while safe and effective
- Can enter system at any level and move as needed.
Complications Driven Treatment

- No Diagnosis
- Treatment of Complications → No Continuing Care
- Relapse
Diagnosis Driven Treatment

Diagnosis → Program → Aftercare

→ Relapse
Individualized, Clinically-driven Treatment
Client-directed, Outcome-informed
Feedback Informed Treatment

**Outcome Rating Scale**
Brief Instrument that a client uses to rate how they’ve been feeling
1) Individually,
2) Interpersonally,
3) Socially and
4) Overall

**Session Rating Scale**
Brief Instrument that a client uses to evaluate the session based on
1) Relationship
2) Goals & Topics
3) Approach or Method
4) Overall

Source: International Center for Clinical Excellence (ICCE)
www.scottdmiller.com
Consistent with Current Thought in providing EBP in Behavioral Health

ASAM Consistent with and Reinforces these Approaches to Care in addition to BH Redesign
New and Important ASAM Terms

- Move beyond “placement” to challenge the idea that placing people in treatment is the “primary and sufficient” goal.

- “Withdrawal Management” – The liver detoxifies; clinicians manage withdrawal.
New and Important ASAM Terms

- Co-Occurring Mental Health and Substance-Related Conditions and Disorders
  - Co-Occurring Capable
  - Co-Occurring Enhanced
  - Complexity Capability

- Opioid Treatment Services – includes all meds to treat opioid disorders

- Clinically Managed Population-Specific High Intensity Residential Services
New and Important ASAM Terms

- Older adults
- Parent or Parents to be in addiction treatment with their children
- “Safety-sensitive” Occupations
- Persons in criminal justice settings
- Gambling Disorder
- Tobacco Use Disorder
AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT

ASAM’s criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:

<table>
<thead>
<tr>
<th>DIMENSION 1</th>
<th>Acute Intoxication and/or Withdrawal Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploring an individual’s past and current experiences of substance use and withdrawal</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIMENSION 2</th>
<th>Biomedical Conditions and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploring an individual’s health history and current physical condition</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIMENSION 3</th>
<th>Emotional, Behavioral, or Cognitive Conditions and Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploring an individual’s thoughts, emotions, and mental health issues</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIMENSION 4</th>
<th>Readiness to Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploring an individual’s readiness and interest in changing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIMENSION 5</th>
<th>Relapse, Continued Use, or Continued Problem Potential</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploring an individual’s unique relationship with relapse or continued use or problems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DIMENSION 6</th>
<th>Recovery/Living Environment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Exploring an individual’s recovery or living situation, and the surrounding people, places, and things</td>
</tr>
</tbody>
</table>
Dimension 1: Acute intoxication and/or Withdrawal Potential

- Assess need for stabilization and type along with intensity of withdrawal management services needed
- Avoid consequences of discontinuation of drug/alcohol use
- Engage and facilitate the patient to complete withdrawal management
- Link to appropriate services (medical, mental health, recovery support etc.)
- Promote patient dignity and ease discomfort using the continuum
Dimension 2: Biomedical Conditions & Complications

- Assess the need for Physical Health Services
- Are there needs for acute stabilization and/or ongoing disease management for chronic physical health conditions which could include
  - Diabetes
  - Cardiovascular
  - Chronic pulmonary disease
  - MRSA infections
  - Arthritis
Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications

- Assess the need for mental health services
- Mental health conditions include Trauma related conditions, Cognitive conditions and developmental disorders in addition to psychiatric illnesses.
- Spiritual aspects – related to and individuals feeling of PURPOSE, their connection to a HIGHER POWER or TRANSCENDENCE.
Dimension 3: Subdomains to assess co-occurring disorders

- Dangerousness/lethality
- Interference with Recovery Efforts for Addiction related issues
- Social Functioning is impaired
- Ability for Self Care
- Course of Illness
Dimension 4: Readiness for Change

- Assess the stage of change they are currently in
  - Often a client is at different stages of change for different issues
  - Contemplation stage for SUD but in action stage for anxiety

- Assess the need for motivational enhancement services and strategies that are most effective.

- Understand variability in “readiness and confidence to change” facilitates more accurate engagement and individualized stage matched services

- Research indicates that when the tasks of each stage of change are completed – long term recovery is greater
Dimension 5: Relapse. Continued use or Continued Problem Potential

- Assesses the need for relapse prevention services
- Assesses potential for continued use for those who have not yet achieved a period of recovery.
- Also any continued problem such as gambling, eating disorders, mental health disorders, trauma
- A strong focus on previous periods of sobriety or wellness and what was successful.
Dimension 6: Recovery and Living Environment

- Exploring individuals living arrangements
- Exploring people and places that could be supportive to sustaining recovery
- Exploring things, place and individuals who could be triggers for relapse
Let’s Stretch and Take a Break
Biopsychosocial Assessment Elements

- Biopsychosocial Assessment Elements
- History of the present episode
- Family history
- Developmental history
- Alcohol, tobacco, other drug use, addictive history
- Personal/social history
- Legal history
- Psychiatric history
- Medical history
- Spiritual history
- Review of systems – including present and past
- Medical/psychological symptoms
- Mental Status Exam
- Physical examination
- Formulation and diagnoses
- Survey of assets, vulnerabilities and supports
- Treatment recommendations

These components are collected in the assessment process and are organized in the ASAM dimensions
Biopsychosocial Treatment - Overview: 5 M’s

- **Motivate** – co-occurring disorders clients can have a lack of interest and passivity about their addiction and mental health problems; deal with sustain talk and lack of interest at a pace that keeps the patient engaged in treatment; family and healthcare workers may also need “motivating” to deal with both addiction and psychiatric issues equally. (Dimension 4)

- **Manage** - because co-occurring disorders clients easily present to both addiction and mental health programs, treatment is more case management across the addiction and mental health treatment systems, social welfare, legal, and family systems and significant others, than individual therapy; case management especially important for high risk, multi-problem and chronic relapsing clients; take a total systems approach; to improve outcomes, alternative services may be necessary e.g. educational or vocational services, child care and parenting training, financial counseling, coping with feelings and dual relapse groups, daily living skills, tutoring or mentoring services, transportation. (Dimensions 1 - 6)
Biopsychosocial Treatment - Overview: 5 M’s

- **Medication** - for a diagnosed co-morbid psychiatric disorder, but only after sufficient assessment strategies exclude addiction mimicking; also for withdrawal management if necessary; educate clients about their medication and interaction with alcohol/drugs; prepare them on how to deal with conflicts about medication at AA/NA meetings; anti-addiction medication: naltrexone (Vivitrol), acamprosate (Campral); disulfiram (Antabuse); methadone; buprenorphine; opioid antagonists. (Dimensions 1, 2, 3, 5)

- **Meetings** - mainstream into AA and NA as much as possible, but prepare clients on how to not alienate themselves e.g. too readily discussing medication and mental health issues unless with an understanding member or group; help clients deal with their “dual identity”; help identify appropriate meetings in the area and locate or develop special support groups for those unable to be “mainstreamed”. (Dimensions 3, 4, 5, 6)
Biopsychosocial Treatment - Overview: 5 M’s

- Monitor - to ensure continuity of care, be alert to missed appointments; hospitalizations and professionals unfamiliar with dual diagnosis and the treatment goals e.g. drug-free diagnostic trial; promote accountability for an ongoing treatment plan, rather than fragmented response to crises; recognize treatment as a process, not an event. (Dimensions 1 - 6)
Levels of Service

- As assessment material is organized into the dimensions, severity for each dimension is considered

- ASAM has four levels of service and an early intervention level for both adolescents and adults
<table>
<thead>
<tr>
<th>ASAM Levels of Care</th>
<th>Level</th>
<th>Same levels of care for Adolescent except Level 3.3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 0.5: Early Intervention Services</strong></td>
<td>0.5</td>
<td>Criteria for assessment and education services for individuals with problems or risk factors related to substance use, but for whom an immediate Substance Related Disorder cannot be confirmed. Further assessment is warranted to rule in or out addiction.</td>
</tr>
<tr>
<td><strong>Level 1 Outpatient Services</strong></td>
<td>1</td>
<td>Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies</td>
</tr>
<tr>
<td><strong>Level 2.1 Intensive Outpatient</strong></td>
<td>2.1</td>
<td>9 or more hours of service/week (adults); 6 - 19.9 hours/week (adolescents) to treat multidimensional instability</td>
</tr>
<tr>
<td><strong>Level 2.5 Partial Hospitalization Services</strong></td>
<td>2.5</td>
<td>20 or more hours of service/week for multidimensional instability not requiring 24 hour care. Level II encompasses services that are capable of meeting the complex needs of people with addiction and co-occurring conditions. It is an organized outpatient service that delivers treatment services usually during the day as day treatment or partial hospitalization services.</td>
</tr>
<tr>
<td>ASAM Levels of Care</td>
<td>Level</td>
<td>Same levels of care for Adolescent except Level 3.3</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td><strong>Level 3 Residential/Inpatient Services</strong></td>
<td>3.1</td>
<td>24 hour structure with available trained personnel; at least 5 hours of clinical service/week</td>
</tr>
<tr>
<td>Clinically-Managed Low-Intensity Residential</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Clinically-Managed Population Specific High Intensity Residential Services</strong></td>
<td>3.3</td>
<td>24 hour care with trained counselors to stabilize multidimensional imminent danger.</td>
</tr>
<tr>
<td><strong>Clinically-Managed High-Intensity Residential -</strong></td>
<td>3.5</td>
<td>24 hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment.</td>
</tr>
<tr>
<td>ASAM Levels of Care</td>
<td>Level</td>
<td>Description</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Medically-Monitored Intensive Inpatient Services – Adult</td>
<td>3.7</td>
<td>24 hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability</td>
</tr>
<tr>
<td>Medically-Monitored High Intensity Inpatient Services - Adolescents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 4 Medically-Managed Intensive Inpatient Services</td>
<td>4</td>
<td>24 hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment</td>
</tr>
</tbody>
</table>
Principle for Assessing Risk

- Risk is multidimensional and Bio-psychosocial
- Risk relates to the individual’s story
- Risk is expressed in current status (how acute, unstable and active)
- Risk involves a degree of change from baseline observation to an escalation of problems.
What is Risk Rating?

- **0-4**
  - 4-UTMOST SEVERITY
  - 3-SERIOUS ISSUES
  - 2-MODERATE DIFFICULTY
  - 1-MILDY DIFFICULT
  - 0-VERY LOW RISK
<table>
<thead>
<tr>
<th><strong>ASAM Criteria-RISK RATING CROSSWALK</strong></th>
<th><strong>ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders - Adult</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Intoxication and/or Withdrawal Potential</strong></td>
<td>0</td>
</tr>
<tr>
<td>Fully functioning, no signs of intoxication or withdrawal present.</td>
<td>Mild to moderate intoxication interferes with daily functioning, but does not pose a danger to self or others. Minimal risk of severe withdrawal.</td>
</tr>
<tr>
<td><strong>Biomedical Conditions and Complications</strong></td>
<td>Fully functioning and able to cope with any physical discomfort or pain.</td>
</tr>
<tr>
<td>Emotional, Behavioral or Cognitive (EBC) Conditions and Complications</td>
<td>0</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Good impulse control and coping skills and subdomains (dangerousness/lethality, interference with recovery efforts, social functioning, self-care ability, course of illness).</td>
<td></td>
</tr>
<tr>
<td>There is a suspected or diagnosed EBC condition that requires intervention, but does not significantly interfere with tx. Relationships are being impaired but not endangered by substance use.</td>
<td></td>
</tr>
<tr>
<td>Persistent EBC condition, with symptoms that distract from recovery efforts, but are not an immediate threat to safety and do not prevent independent functioning</td>
<td></td>
</tr>
<tr>
<td>Severe EBC symptomatology but sufficient control that does not require involuntary confinement. Impulses to harm self or others, but not dangerous in a 24-hr setting.</td>
<td></td>
</tr>
<tr>
<td>Severe EBC Symptomatology requires involuntary confinement.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Readiness to Change</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willing, engaged in treatment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Willing to enter treatment, but is ambivalent about the need for change. Or willing to change substance use, but believes it will not be difficult to do so.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reluctant to agree to treatment. Able to articulate negative consequences of usage but has low commitment to change use. Only passively involved in treatment.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unaware of the need for change, minimal awareness of the need for treatment, and unwilling or only partially able to follow through with recommendations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not willing to explore change, knows very little about addiction, and is in denial of the illness and its implications. Unable to follow through with recommendations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## ASAM Criteria - RISK RATING CROSSWALK
### ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders - Adult

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relapse, continued use-problem potential</td>
<td>Low or no potential for relapse, good coping skills</td>
<td>Minimal relapse potential, some vulnerability, fair self management and relapse prevention skills</td>
<td>Impaired recognition and understand of substance use, relapse issues but able to self manage with prompting.</td>
<td>Little recognition and understanding of substances use, relapse issues, and poor skills to interrupt addition problems or to avoid or limit relapse.</td>
<td>Environment is chronically hostile and toxic to recovery. Patient is unable to cope with negative effects of the environment and this poses threat to sobriety.</td>
</tr>
<tr>
<td>Recovery Environment</td>
<td>Supportive environment and able to cope in environment.</td>
<td>Passive support or others are not interested in patients recovery however patient is not distracted by this and able to cope</td>
<td>Environment not supportive of recovery but clinical structure able to cope most of the time to support recovery.</td>
<td>Environment not supportive of healthy recovery and patient finds coping difficult even with clinical structure.</td>
<td>Environment is hostile – toxic to recovery. Patient unable to cope with negative effects of environment and this poses threat to recovery.</td>
</tr>
</tbody>
</table>
# Withdrawal Management Levels

<table>
<thead>
<tr>
<th>ASAM Third Addition - Level of Withdrawal Management Service for Adults</th>
<th>Level</th>
<th>Note: There are no separate withdrawal management Services for Adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Withdrawal Management without Extended On-Site Monitoring</td>
<td>1-WM</td>
<td>Mild withdrawal with daily or less than daily outpatient supervision; likely to complete withdrawals and to continue treatment or recovery</td>
</tr>
<tr>
<td>Ambulatory Withdrawal Management with Extended On-Site Monitoring</td>
<td>2-WM</td>
<td>Moderate withdrawal with all day support and supervision; at night, has supportive family or living situation;</td>
</tr>
<tr>
<td>Clinically-Managed Residential Withdrawal Management</td>
<td>3.2-WM</td>
<td>Moderate withdrawal, but needs 24-hour support to complete withdrawal and increase likelihood of continuing treatment or recovery</td>
</tr>
<tr>
<td>Medically-Monitored Inpatient Withdrawal Management</td>
<td>3.7-WM</td>
<td>Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal without medical, nursing monitoring</td>
</tr>
<tr>
<td>Medically-Managed Intensive Inpatient Withdrawal Management</td>
<td>4-WM</td>
<td>Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal regimen and manage medical instability</td>
</tr>
</tbody>
</table>
Redesign Projected Rates

- Based on approval by CMS
- Can be found on BH.Medicaid.ohio.gov
- Located on resource tab
- Document is coverage and limitations workbook
- Some levels are per diem rates
<table>
<thead>
<tr>
<th>Unit of Measure</th>
<th>CPT/HCPCS</th>
<th>Procedure Code</th>
<th>Pricing Modifier(s)</th>
<th>Description</th>
<th>Medical Behavioral Health (BH) Practitioners</th>
<th>Independent BH Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 Minutes</td>
<td>ASAM 2a</td>
<td>H0035</td>
<td>AF</td>
<td>Alcohol and/or drug services; group counseling by a physician</td>
<td>NA</td>
<td>$8.49</td>
</tr>
<tr>
<td>15 Minutes</td>
<td>ASAM 2b</td>
<td>H0035</td>
<td>AF</td>
<td>Alcohol and/or drug services; individual counseling</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>30 Minutes</td>
<td>ASAM 3a</td>
<td>H0039</td>
<td>AF</td>
<td>Alcohol and/or drug services; acupuncture</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>45 Minutes</td>
<td>ASAM 3b</td>
<td>H0039</td>
<td>AF</td>
<td>Alcohol and/or drug services; acupuncture and Qigong</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>60 Minutes</td>
<td>ASAM 4a</td>
<td>H0039</td>
<td>AF</td>
<td>Alcohol and/or drug services; inpatient treatment</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>90 Minutes</td>
<td>ASAM 5a</td>
<td>H0039</td>
<td>AF</td>
<td>Alcohol and/or drug services; inpatient treatment</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>120 Minutes</td>
<td>ASAM 6a</td>
<td>H0039</td>
<td>AF</td>
<td>Alcohol and/or drug services; inpatient treatment</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

Note: The table continues with similar entries for different units of measure and descriptions.
<table>
<thead>
<tr>
<th>Outpatient</th>
<th>Intensive Outpatient</th>
<th>Partial Hospitalization</th>
<th>Residential</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents: Less than 6 hrs/wk&lt;br&gt;Adults: Less than 9 hrs/wk</td>
<td>Adolescents: 6 to 19.9 hrs/wk&lt;br&gt;Adults: 9 to 19.9 hrs/wk</td>
<td>Adolescents: 20 or more hrs/wk&lt;br&gt;Adults: 20 or more hrs/wk</td>
<td>Per Diems supporting all six residential levels of care including:&lt;br&gt;- clinically managed&lt;br&gt;- medically monitored&lt;br&gt;- two residential levels of care for withdrawal management</td>
</tr>
<tr>
<td>- Assessment&lt;br&gt;- Psychiatric Diagnostic Evaluation&lt;br&gt;- Counseling and Therapy&lt;br&gt;  - Psychotherapy – Individual, Group, Family, and Crisis&lt;br&gt;  - Group and Individual (Non-Licensed)</td>
<td>- Assessment&lt;br&gt;- Psychiatric Diagnostic Evaluation&lt;br&gt;- Counseling and Therapy&lt;br&gt;  - Psychotherapy – Individual, Group, Family, and Crisis&lt;br&gt;  - Group and Individual (Non-Licensed)</td>
<td>- Assessment&lt;br&gt;- Psychiatric Diagnostic Evaluation&lt;br&gt;- Counseling and Therapy&lt;br&gt;  - Psychotherapy – Individual, Group, Family, and Crisis&lt;br&gt;  - Group and Individual (Non-Licensed)</td>
<td>- Medications&lt;br&gt;- Buprenorphine and Methadone Administration&lt;br&gt;- Urine Drug Screening&lt;br&gt;- Peer Recovery Support&lt;br&gt;- Case Management</td>
</tr>
<tr>
<td>Medical&lt;br&gt;Medications&lt;br&gt;Buprenorphine and Methadone Administration&lt;br&gt;Urine Drug Screening&lt;br&gt;Peer Recovery Support&lt;br&gt;Case Management</td>
<td>Medical&lt;br&gt;Medications&lt;br&gt;Buprenorphine and Methadone Administration&lt;br&gt;Urine Drug Screening&lt;br&gt;Peer Recovery Support&lt;br&gt;Case Management</td>
<td>Medical&lt;br&gt;Medications&lt;br&gt;Buprenorphine and Methadone Administration&lt;br&gt;Urine Drug Screening&lt;br&gt;Peer Recovery Support&lt;br&gt;Case Management</td>
<td>Medications&lt;br&gt;Buprenorphine and Methadone Administration</td>
</tr>
<tr>
<td>Level 1 Withdrawal Management (billed as a combination of medical services)</td>
<td>Additional coding for longer duration group counseling/psychotherapy&lt;br&gt;Level 2 Withdrawal Management (billed as a combination of medical services)</td>
<td>Additional coding for longer duration group counseling/psychotherapy&lt;br&gt;Level 2 Withdrawal Management (billed as a combination of medical services)</td>
<td>Level 2 Withdrawal Management (billed as a combination of medical services OR 23 hour observation bed per diem)</td>
</tr>
<tr>
<td>Code</td>
<td>Modifier 1</td>
<td>Modifier 2</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
</tbody>
</table>

**General Medicaid Benefit Limit Guidance** (If service is used in MH setting - Provider type 84 - see below guidance)

- **ASAM Outpatient Benefit Limit Guidance (Adults: 21 and older)**
- **ASAM Outpatient Benefit Limit Guidance (Adolescents: Under 21)**

### Medical Services

#### Counseling and Therapy

- Crisis

#### Screening, Assessment and Psychological Testing

- SUD Outpatient Services - Group Counseling
- SUD Intensive Outpatient Group Counseling
- SUD Partial Hospitalization Group Counseling

#### Other Services
LICDC Rendering Modifier: No modifier needed

This tab excludes SUD Residential and SUD Withdrawal Management (Please see the provider manual for additional guidance)

<table>
<thead>
<tr>
<th>Code</th>
<th>Modifier 1</th>
<th>Modifier 2</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>General Medicaid Benefit Limit Guidance (If service is used in MH setting - Provider type 84 - see below guidance)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ASAM Outpatient Benefit Limit Guidance (Adults: 21 and older)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>ASAM Outpatient Benefit Limit Guidance (Adolescents: Under 21)</td>
</tr>
</tbody>
</table>

### Medical Services

#### Counseling and Therapy

#### Crisis

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Level of Care Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>90839</td>
<td>Psychotherapy for crisis; first 60 minutes.</td>
<td>Does not count towards weekly level of care hours</td>
</tr>
<tr>
<td>+90840</td>
<td>Psychotherapy for crisis; each additional 30 minutes.</td>
<td>Does not count towards weekly level of care hours</td>
</tr>
</tbody>
</table>

#### Screening, Assessment and Psychological Testing

- SUD Outpatient Services - Group Counseling
- SUD Intensive Outpatient Group Counseling
- SUD Partial Hospitalization Group Counseling

### Other Services
### Scenario (patient-specific weekly IOP schedule)

On Monday, Wednesday and Friday, the patient receives **2 hours and 30 minutes of group counseling**, **1 hour of individual psychotherapy** and **30 minutes of peer recovery support**, the group counseling is provided by a LICDC and a CDCA (co-facilitators), the individual psychotherapy is provided by an LISW and the peer recovery support is provided by a certified peer recovery supporter. On Tuesday and Thursday the patient and their significant other receive **1 hour of family psychotherapy** by an LISW and **30 minutes of case management** provided by a care management specialist. On Sunday, the individual receives **1 hour of peer recovery support**. On Thursday, the patient is called for an **unscheduled urine drug screen**.

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>Service Name</th>
<th>Enc./Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0015 (HK)</td>
<td>2 hours 30 mins</td>
<td>IOP Group Counseling Lead by LICDC with CDCA assisting</td>
<td>Per Diem = 1</td>
</tr>
<tr>
<td>90837</td>
<td>1 hour</td>
<td>Psychotherapy 1 hour by LISW</td>
<td>Encounter = 1</td>
</tr>
<tr>
<td>H0038</td>
<td>30 min</td>
<td>Peer Recovery Support by PRS</td>
<td>Unit based (15 minutes) = 2</td>
</tr>
</tbody>
</table>

**Tuesday and Thursday**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>Service Name</th>
<th>Enc./Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>90847</td>
<td>1 hour</td>
<td>Family psychotherapy by LISW</td>
<td>Encounter = 1</td>
</tr>
<tr>
<td>H0006</td>
<td>30 min</td>
<td>Case Management by CMS</td>
<td>Unit based (15 minutes) = 2</td>
</tr>
<tr>
<td>Thursday only: H0048</td>
<td>1 unit</td>
<td>Urine Drug Screening - unscheduled</td>
<td>Collection and 1-Cup, if applicable</td>
</tr>
</tbody>
</table>

**Sunday**

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
<th>Service Name</th>
<th>Enc./Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>H0038</td>
<td>1 hour</td>
<td>Peer Recovery Support by PRS</td>
<td>Unit based (15 minutes) = 4</td>
</tr>
</tbody>
</table>

**Other Considerations:**

1. Choose the code that best aligns with the service delivered and all documentation must support the billed service.
2. Ensure that services are provided within scope of practitioner
3. IOP level of care is between 9-19.9 hours for adults and 6-19.9 hours for adolescents

Scenario is for **illustrative purposes only** for today’s training.
Connection to Motivational Interviewing (MI)

We might be CORRECT that an individual is best suited for a particular level of care, but we won't be EFFECTIVE if we insist they are placed in that level.

– Important role of assessing Dimension 4
– MI starts with engagement, uses focusing and evocation to move toward change planning
– Motivation shifts throughout levels of care and treatment. MI provides skills to respond to client’s changing motivation by engaging, re-engaging and GUIDING toward change.
Multi-Dimensional Assessment

What does the client Want? Why Now?

Does Client have immediate needs due to imminent risk in any of the six assessment dimensions?

Identify which assessment dimensions are currently most important to determine TX priorities

Choose a specific focus and target for each priority dimension

What specific services are needed for each dimension

What intensity of service is needed for each dimension identified?

Where can these services be provided, in the least intensive, but safe level of care.

Monitor progress of treatment plan/placement decision. What are the outcome measurements?
A Note on Level of Functioning in Multi-Dimensional Assessment

“A good treatment program will be looking not just at pathology in these areas (dimensions), but what are their (the client’s) strengths, skills and resources.”

Dr. David Mee-Lee, M.D.
Recovery Capital

- Recovery capital (RC) is the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery from severe AOD problems
  - Personal recovery capital
  - Family/social recovery capital
  - Community recovery capital
Recovery Capital in Placement Decisions

HIGH RECOVERY CAPITAL  
HIGH PROBLEM SEVERITY/COMPLEXITY

LOW PROBLEM SEVERITY/COMPLEXITY  
LOW RECOVERY CAPITAL
Continued Service and Discharge Criteria

- After the admission criteria for a given level of care have been met, the criteria for continued service, discharge or transfer from that level of care are as follows:

Continued Service Criteria: It is appropriate to retain the patient at the present level of care if:

- The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

OR

Continued Service Criteria: The patient is making progress, but has not yet achieved the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;
Continued Service Criteria

- The patient is not yet making progress but has the capacity to resolve his or her problems. He or she is actively working on the goals articulated in the individualized treatment plan. Continued treatment at the present level of care is assessed as necessary to permit the patient to continue to work toward his or her treatment goals;

  and/or

- New problems have been identified that are appropriately treated at the present level of care. This level is the least intensive at which the patient’s new problems can be addressed effectively.
Discharge/Transfer Criteria

**Discharge/Transfer Criteria**: It is appropriate to transfer or discharge the patient from the present level of care if he or she meets the following criteria:

- The patient has achieved the goals articulated in his or her individualized treatment plan, thus resolving the problem(s) that justified admission to the current level of care;  
  
  or  

- The patient has been unable to resolve the problem(s) that justified admission to the present level of care, despite amendments to the treatment plan. Treatment at another level of care or type of service therefore is indicated;  
  
  or
The patient has demonstrated a lack of capacity to resolve his or her problem(s). Treatment at another level of care or type of service therefore is indicated;

or

The patient has experienced an intensification of his or her problem(s), or has developed a new problem(s), and can be treated effectively only at a more intensive level of care.

To document and communicate the patient’s readiness for discharge or need for transfer to another level of care, each of the six dimensions of the ASAM criteria should be reviewed. If the criteria apply to the existing or new problem(s), the patient should be discharged or transferred, as appropriate. If not, refer to the Continued Service criteria.
GROUP SCENARIOS
Scenario 1

- Tyler, age 21, was ordered for an assessment after being arrested for open container on a college campus. He states he was at a fraternity party that evening and was walking down to another fraternity house with an open can of beer when stopped by police.

- During the assessment, he stated that he has never had a DUI, denies loss of control while drinking but can consume on an average weekend a case of beer from Friday through Sunday depending on the event. He admits to smoking marijuana on occasion but only smokes when he wants to mellow out. Last usage was a month ago. Some experimental usage with other substances however no usage within the two months. He identified using cocaine with several events but has not used this for four months. He denies He denies any withdrawal issues, memory issues or problems associated with his usage. He denies any problems with cravings, shakes, sweats and denies any type of blackouts. He has never been treated for any substance related or mental health disorders.

- He is an average student, is working for the university along with attending classes. He describes his grandfather as active alcoholic but denies any other family members having problems. Good relationships with family. He denies any other legal issues.
Scenario 2

- Stella, a 42 year old bar tender was brought in for an evaluation after her family found her passed out on the front porch from the night before. She stated that she has been using heroin for the past 6 months and has not been able to decrease or discontinue her usage. She uses 3-4 bags a day most of the week unless she is unable to afford that quantity. Stella denies using any other illegal substance but says she does use alcohol on occasion to get her through rough patches, shakes and sickness.

- Stella has had prior treatment. She stated that she has been in intensive out-patient twice within the last year but has relapsed each time shortly after discharge. She states she has little motivation to remain clean. Family is tired of her behavior and is not willing to support her any longer. She has divorced within the last 5 years, stating that her husband cheater on her. She has had several DUI’s in her past but has not had any in 10 years.

- She appears depression. Affect is flat, expresses little motivation or desire to change. She states she has no place to live, was evicted from her apartment and has not clean and sober friends to help her stay clean.

- Stella appears malnourished, hair is thin and states she has a chronic cough. She does smoke around two packs of cigarettes a day.
Thank you.....

Brad & Joyce